Appendix 10

Informed Consent to Release/Obtain Health Care Information Form (Sample Format)

Agency Name: _____ Telephone #: _____

Address: _____

_____

Client's Name: _____ Medicaid ID #: _____

Address: _____ Date of Birth: _____

_____

Telephone Number: _____

I, _____ (*print client's name*), give consent for _____ (*print name of care coordination provider)* to release health/social services information to, and obtain information from, _____ (*print name of other provider/agency to which, or from which, you are requesting information)* for the person named above. The information is to be used to assist me in monitoring and coordinating health care and social services.

The information to be disclosed includes:

_____

_____

_____

Do not disclose the following information:

_____

_____

_____

This authorization shall be valid from the signature date until _____ *(print the date)*, and may be revoked by me at any time (except as it has already been used).

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____